Continuing Care Legal Workgroup Minutes
September 13, 2013
Spring Grove Hospital Center (Dix Building Room 129)

Next meetings: 9/20; 9/27

Pros & Cons due 9/18

Participants on phone:
Scott Rose
Mike Finkle
Nancy Rosen-Cohen
Anita Everett
Kat Kangilinan

Attendees:
Meg Garrett
Randall Nero
Brian Hall
Nevett Steele
Dan Malone
Dan Martin
Denise Sulzbach
Laura Cain
Erik Roskes
Janet Edelman
Michael Flannery
Stacy Reid Swain

Purpose: get moving so issues can get on the table to prepare report for Oct. 4; pick two more meeting dates

Identify issues and barriers; pros and cons – what to consider more than recommendations

Six areas:

Housing

- Barrier, people get discharged without places to live
- What legally, in terms of general things can be done
- Legal right to housing? Unlikely
- Problematic: people in community programs and housing is part of that, often times get complaints of people threatened with eviction or are evicted for reasons unrelated to landlord-tenant law; eviction is result of a landlord being provider/tenant is consumer – clinical provider rules
- Housing provider: (Scott Rose)
    - Really complicated issues, spent 5 years on residential rehab program regs, solving problems seems to cause more problems, the regs are designed to be licenses not landlord/tenant regs – want protection for consumer but have to balance the others in the house or building
    - Not easy solution, can relook at RRP regs; tried to suggest can only be asked to leave if safety issues are beyond what housing provider could addess or imminent danger to self or others (30 days notice); not bound to landlord tenant laws
- Is there need for more?
    - Debate about bundle v. unbundle housing from services
    - There is a housing shortage

        - With revolving door in and out of treatment people can lose their spot
    - Legally what to do? Housing first model? Person has housing regardless of any other service accepted or no accepted – landlord tenant – make housing permanent and services come in and out according to need
    - Some models like that already – expansion of Housing First model, some people need RRP model esp coming out of hospitals, RRP authorizations have been frozen and haven't kept up with the need
        - Need to look at private pay v Medicaid pay
        - Issues with RRP private pay beds authorized – this should be unrestricted if someone meets criteria and can private pay
- Assisted living regs
    - Encompassed what use to be boarding care; those regs have been designed with main focus on elderly for ALFs which add a considerable cost burden when a lot of these care people are taking people into their home
    - Need separate regs for people that are younger board and care type places
- Exclusion issues
    - Questions from social workers on behalf of patients leaving the hospital about people that have committed violent crimes but not held responsible – issue with exclusion from housing?
    - Other restrictions from drug offenders that can restrict
    - Provider liability issues (i.e. for sex offenders)
    - A lot of power is in hands of public housing authority in each jurisdiction
- **Can someone make a table for type of housing and issues specific to each – public v. private? (Sarah Rein – housing department?)**
    - **Consider shelters at local level and problems with getting people in shelters**
    - Some issues are being considered by financial and other workgroups
- Back to Legal issues
    - If someone is discharged from hospital and there is no housing available?
    - Legally can you prevent discharge?
        - Hospitals have limited resources to do this
        - What about shelters?
        - Would depend on who is responsible for individual – public mental health system DHMH doesn't take responsibility for discharge; that is on hospital – there is a disconnect
        - What about case manager being responsible for continuing care – some sates have case management as central core of system
        - Question of legal entitlement – do you have right to have services regardless of where you are?
    - Are rights of patients violated if discharged to street b/c no longer danger to self or others because they don't meet criteria to get into housing
        - Patients have a choice to be discharged – if have capacity have right to leave and that isn't going to change legally
- Outcome: clarifying memos as to what legal remedies for these things – i.e. housing if there is confusion in field on something like what convictions preclude section 8 vs. what is local authority – may suggest legal clarification memos as recommendation
- In MoCo core service agency requires RRP housing applications are renewed every 6 months – it's a strain on someone who doesn't have capacity to begin with; it thins the list. It used to be 1 application
    - Same issues in NYC – based on clinical status change
    - Maybe addendum or reverify interest
- Delays in RRP referrals – need some work if you're at a county can take too long for referral process – but can we do anything legally here?

<u>Accountability for Provider/Laws regarding Discharge from hospital</u>

- Require at least more document of what efforts were to even find housing or services – needs some oversight of the hospitals
- DHMH looks into complaints, but how many homeless people are going to complain?
- 10-809 aftercare statute – services to include supportive housing the statute doesn't say there has to be a plan for supportive housing
- Can't require hospital to provide, but you can require them to look
    - Not sure that this is a feasible requirement – maybe this is a social problem
    - There are some reqs with Joint Commission
    - Should DHMH really need to put together a packet for discharge of every patient and their plans
- **Resend 10-809**
- Joint Commission requirement/ CMS COP to contact family in discharging if they family is part of the continuing care (where family is involved is contact required?)
    - Does it need to be required?
    - Problem is if they say they don't want family involved
    - Family is not required by statute but JHACO basically has force of law
        - It is in regs to contact family for service plan
    - **Maybe have clarification here on discussion of families not a new reg**
    - Person has right to have advocate of their choosing in discharge planning
    - What about requiring a time notification – ie notify family at least 24 hours before
        - Is this a clinical practice issue – should it be legislated?
        - Legislate licensure
        - Is solution education to consumers and family to show how to investigate/complain/contact DHMH in complaint process
        - Education to providers
        - **clarification on discussion of families in after-plan, clarification of public agencies on discharge of wards from psychiatric facilities**
    - Communication issues
- Legal issue: Jackson limits for IST cases – way too long, much longer than other states; results in people staying for too long – occupying beds far longer than necessary – stay held until judge thinks treatment plan is adequate even after treatment
    - Where should it be/solution? Length of commitment needs to relate to purpose
    - Once problem is identified case shouldn't be staying open
    - Putting limits on treatment – there should be short timeframes and MD doesn't have that – 4 months misdemeanor (3 years) 1 year (5 years v 10 years for other capital offenses)
    - **Statutory change to give discretion to courts, not to follow min or max**
    - Two issues; at 4 months or 1 year we call it a day and release or civilly commit; charges are separate and they keep being folded into the same thing
        - Problem is when statute get opened, judiciary is going to take control
        - Mentalcompentency.org for IST practices
    - Sometimes might hold open cases for lack of discharge plan

Confidentiality

- Have fed, state, and mental health laws
- Issue in front of Congress is:
    - Admissions to multiple hospitals there is no continuity of sharing information; no interaction between families and hospital – issues with getting records, no central depository for records
    - CRISP? Does it apply to behavioral health/psychiatric? No
        - Need something like this for psychiatric
        - ACA requires electronic? No – requires hospitals to have their own data systems, not necessarily sharing
        - MD and JHH share via EPIC
    - Can we require something like EPIC or CRISP?

        - When CRISP was formed, mental health community didn't want it
        - Parity issue?
    - Try to expand CRISP to include mental health information
    - **Potential legal efficacy – since patients have ability to opt out this should constitute consent for including behavioral health info**
        - What about patients right, when do they get to opt out; what if incapable at intake? What happens to record if people opt out after the fact?
        - Are there creative avenues to work with HIPAA to massage consent **(Scott Rosen – first mental health provider to try to use CRISP – willing talk to CRISP/AG (with Mike Finkle & Dan Malone)** – can't push info to hospitals because its behavioral health information)
        - Medicaid unit at DHMH may also be addressing this
        - Have to look at MD law and HIPAA for each issue
    - **Recommendation: Clarify that providers can talk to each other safe from HIPAA in ongoing care** – get nice easy language clarification for providers, family members, police, hospitals, consumers/patient rights – providers need to get on board
    - Challenge with psych and clinical units sharing information – clinical and social issue
    - **Recommendation: See if CRISP can extend to jails and also health care providers**
        - Include a summary of advisory report (??)
- Legislature ought to require county correctional facilities to be licensed health care facilities and inspected by DHMH
    - **Recommendation: Licensing of country detention facilities and juvenile facilities as health care facilities**
- Issue with Maryland judiciary search and not being able to get rid of suits on there that may disclose information that people sued hospital (i.e. to get out – hearing to get released), get asked about it but should be confidential
    - Issues: requirement/shielding in context of information sharing
    - **Narrow Recommendation: Shielding of cases where patient files habeas to be released from hospital**
        - What about anything that shows resident? Emergency petitions? Protective orders
    - Slippery slope as to what to consider

<u>Guardianship</u>

- Recommendation to waive registry fee for those that can't afford it
- **Recommendation: Education on advance directives**
    - But can be rescinded by patient – what about competency?
    - (Clinical group suggested?) Ulysses clause – if you have advance directive can't rescind until you have capacity
    - would need this in the law about determining capacity
    - see Bill 790
- Would like to hold patient who lacks capacity for 72 hours (non-psych) temporary confinement to get emergency hearing for guardianship without having to commit
    - Need check in there to have someone come in and say OK
    - Patient who lacks capacity
    - **If guardianship has been filed (from time of second certification), institution can retain individual for 3 business days (held until next day courts are in session?) and courts consider expedited emergency process**
- Recommendation (?): Can a guardian voluntarily commit with two certs? Have guardian statute be open – not require a hearing.
    - But what about due process? Must be balanced with consumers
    - Process that is less burdensome than involuntary

    - Question whether this is a real problem
    - What about conditional releases….
- **Recommendation needs to be collecting data if recs are based on anecdotes**